

#### Dr. D. Graeme Shaw acquired the practice of Dr. Claude Marquette in April 1998, after working with the practice since September of 1996. He continues with a like minded philosophy of medical treatment; emphasizing natural and nutritional means to restore patients’ health.

Dr. Shaw received his medical training at Creighton University of Medicine, voted one of "America’s best colleges". He spent three years specializing in Internal Medicine at the St. Louis University Hospital, and is board-certified in Internal Medicine.

For almost 20 years he concentrated on both acute and chronic illnesses; including Lyme and mold disease. Those years of hospital based practice made him appreciate the many benefits of western medical technology, but it also revealed the deficiencies western medicine has in dealing with chronic illness and preventative medicine. Dr. Shaw is a member of ACAM, The American College for the Advancement of Medicine. He is also a member of ILADS, The International Lyme and Associated Diseases Society.

Nutrition is a basic treatment for many illnesses we see these days. Our environment, soil and foods have lost the nutrient value they once had. Reversing this “malnutrition” can treat many disorders. Dr. Shaw has been practicing nutritional and preventative medicine since 1994 and is experienced with many treatments including chelation (removal of heavy metal toxins) and herbal therapies.

Dr. Shaw will work with each patient to create a treatment plan that draws from a variety of modalities including intravenous therapy, herbal supplements, diet and nutrition, life style counseling and any necessary medications. The plan will set goals to alleviate pressing symptoms and address the underlying dysfunction in order to restore or heal the body and return it to a healthy balance.

Dr. Shaw has done extensive research on cell membrane hyper-excitability and neurotransmitter dysfunction. Together with Dr. Ba Hoang, he has co-authored multiple research papers on the relationship between cell membrane abnormalities and chronic illnesses. Dr. Shaw has demonstrated his commitment to medicine by constant collaboration and research with both his patients and the medical community. Dr. Shaw also produces short videos for students and the inquisitive patient on many subjects.

Open-mindedness, acceptance, and quality time spent is rare among doctors these days. Dr. D. Graeme Shaw makes sure he provides these precious commodities to all his patients.

D. GRAEME SHAW, M.D. 1098 Foster City Blvd, Suite 305

Foster City, CA 94404

650-474-2130

**EDUCATION:**

***CURRICULUM VITAE***

#### San Jose State University 1965-69

San Jose, California BS – Biology Graduated 1969

Creighton University School of Medicine 1969-1973 Omaha, Nebraska

MD degree Graduated 1973

**TRAINING:**

#### St. Mary’s Health Center 1973-74

#### St. Louis, Missouri Medicine/Pediatric Internship

#### St. Mary’s Health Center 1974-76

Internal Medicine Residency

**BOARD CERTIFICATION:**

American Board of Internal Medicine 1976

**EMPLOYMENT:**

Christian Hospitals Trauma Center 1976-82

St. Louis, Missouri Emergency Physician

Queen of the Valley Hospital 1982-94

Napa, California Emergency Physician

Saint Louise Hospital 1994-97

Morgan Hill, California Emergency Physician

SpineMed Clinic 1996-2005

San Jose, California Medical Director

NutriMed 1996-98

Los Altos, California

Integrative Medicine private practice

Natural Immune Supplements Corporation 1996-1999 San Jose, California

Medical Director

Integrative Medicine - Private Practice 1998-Present Los Altos, California

Medical Director/Owner

GetWell International Herbal Company 1999-2005 San Jose, California

Medical Director

GetWell Natural Herbal Company 2005-Present San Jose, California

Medical Advisor

**PUBLICATIONS:**

**Refractory Idiopathic Thrombocytopenic Purpura: An Integrated Approach to Treatment** -- Hoang/Shaw *Journal of Orthomolecular Medicine* **18**(2), 77-82 *Oct/2003* **Hypothesis of the Cause and Development of Neoplasms** -- Hoang/Shaw/Levine *European Journal of Cancer Prevention* 2007, Vol. 16, No. 1

**New Approach in Asthma Therapy Using Excitatory Modulator** -- Hoang/ Shaw/Levine *Phytotherapy Research* **21**, 554-557 (2007)

**Bronchial Epilepsy or broncho-pulmonary hyperexcitability as a model of asthma pathogenesis –** Hoang/Levine/Shaw/Pham/Hoang *Medical Hypotheses* (2006) **67**, 1042-1051

### Neurobiological Effects of Melatonin as Related to Cancer –

Hoang/Shaw/Pham/Levine *European Journal of Cancer Prevention* (2007) **16**: 511-

#### 16

**Neuro-Bioenergetic Concepts in Cancer Prevention and Treatment** – Hoang/Shaw/Pham/Levine *Medical Hypotheses* (2007) **68**, 832-843

**L-Theanine in cancer prevention and treatment –** Hoang/Shaw/Levine

(Abstract) Nov 2006 *AACR International Conference on Frontiers in Cancer Prevention Research*

**Excitatory modulation as a mechanism of vitamin D anticancer activity –** Hoang/Shaw/Levine (Abstract) Nov 2006 *AACR International Conference on Frontiers in Cancer Prevention Research*

**Restoration of Cellular Energetic Balance with L-Carnitine in the Neuro- bioenergetic Approach for Cancer Prevention and Treatment** – Hoang/Shaw/Pham/Levine *Medical Hypotheses* (2007) **69**, 262-272

**Treating Asthma as a Neuroelectrical Disorder** – Hoang/Shaw/Pham/Levine

*Inflammation & Allergy – Drug Targets,* 2010, 9, 130-134

**Lactobacillus rhamnosus cell lysate in the Management of Resistant Childhood Atopic Eczema** – Hoang/Shaw/Pham/Levine *Inflammation and Allergy – Drug Targets* 2010 Jul 1;9(3) 192-6

**Dimethyl Sulfoxide as an Excitatory Modulator and its Possible Role in Cancer Pain Managaement** – Hoang/Levine/Shaw/Tran/Tran et al. *Inflammation and Allergy – Drug Targets* 2010, Nov. 4; 9:306-312

**Dimethyl Sulfoxide and Sodium Bicarbonate in the Treatment of Refractory Cancer Pain –** Hoang/Tran/Pham/Shaw/et al – *Journal of Pain and Palliative Care Pharmacotherapy* Vol. 25, Number 1, March 2011

**Dimethyl Sulfoxide-Sodium Bicarbonate Infusion for Palliative Care and Pain Relief in Patients with Metastatic Prostate Cancer** – Hoang/Le/Tran/Hoang/Shaw et al *Journal of Pain and Palliative Care Pharmacotherapy* Vol. 25, Number 4, December 2011

**Palliative Treatment for Advanced Biliary Adenocarcinomas with Combination Dimethyl Sulfoxide-Sodium Bicarbonate Infusion and S-Adenosyl-L-Methionine** – Hoang/Tran/Vu/Pham/Shaw *Journal of Pain and Palliative Care Pharmacotherapy,* 2014:28:1-6

### LECTURES & PRESENTATIONS:

**An Integrative Approach in Diagnosis and Management of ITP –** Hoang/Shaw

*PDSA Annual Conference 6/02 San Diego, CA*

**LICENSURE:**

California Medical License -- No. G47925 1982-Present

**INTEGRATIVE MEDICAL ASSOCIATES**

**1098 Foster City Blvd. #305 Foster City, CA. 94404 (650) 474-2130**

**INTRODUCTION**

###### Please read all information prior to signing.

Welcome! We strive to provide individualized medical evaluation and treatment in an environment of warmth and caring which is conducive to wellness and a high quality of life. Our philosophy of practice is oriented toward a non-drug approach to medical care, utilizing natural and nutritional therapies and preventive care.

Our work is dedicated to enhancing your wellness through rediscovering and strengthening your own innate healing ability. Integrative Medical Associates seeks to form a working partnership with you, the goal of which is your good health. We invite you to participate as fully as you wish in your own care. Your involvement in your health and healing is vital to our success. We believe our job is to provide the best information and most effective medical care possible.

**OFFICE POLICY**

First appointments are complex and an hour or more is set aside specifically for you, therefore we require a deposit at time of scheduling. Our office policy requests that for all subsequent visits payment be made, in full, at the time of service. We accept personal checks (If paying by check, we require a credit card on file; this credit card will be utilized in the case of a returned check and accompanied by a returned check fee of $25) Visa, Discover or MasterCard . We are a non-insurance facility. We are not participants, nor are we providers, in any insurance plans. We cannot verify if your insurance will reimburse for any of our fees. **We politely encourage you to contact your individual carrier for specific details regarding your policy and its limitations.**

We do not provide insurance billing. After each office visit, you will be provided a form or ‘superbill’ statement containing all necessary information to submit directly to your insurance carrier. The ‘superbill’ can be attached to your insurance form as the “Attending Physician’s Statement” portion of the claim form. Should you require any correspondence i.e. letters written to providers, a fee will be charged based on the complexity.

IMA is not a Medicare provider. Medicare patients cannot bill Medicare for their services in the office. A contract indicating a patient will not bill Medicare is enclosed in this packet.

###### In the signing of consent for an underage child, the parent or guardian is vouching for both parents/guardians in requesting treatment at this office.

The physicians in this office are NOT practicing in any type of legally established partnership or corporation.

Each physician has their own private practice but shares office space.

**FEES**

Our fees are structured around time expenditure and services provided:

*Initial Consultation- including complete History & Physical (60 min.) $550 Follow-up visit -test Result evaluation & therapeutic recommendations (60 min.) $495 Office Visit- for check-ups and therapeutic reevaluation (30 min.) $295*

We welcome your questions and calls about your health. However, at our discretion, a fee will be charged for telephone calls over 3 minutes. Please see the following list for regular phone/video consult fees:

*Brief call (5-10 minutes) $150 Intermediate (11-20 Minutes) $225*

*Extended (21-30 Minutes) $295*

*Please be prepared for your phone or video appointment. If the appointment exceeds the allotted time the next tier fee*

 *will apply.*

\* The above fees reflect office visit charges only. Laboratory fees, nutritional supplements and other services are additional. In addition, as previously indicated we are a *non-insurance facility*. We cannot and do not guarantee any test or procedure will be paid by your insurance. Again, we politely encourage you to contact your individual carrier for specific details regarding your policy.

**OFFICE ROUTINE & HOURS**

We request that you be prepared to make the maximum use of your time with the doctor, by writing down any questions, concerns and other subjects of discussion prior to your visit. It would also suggest you keep a record of what supplements and/or medications you are taking and bring it with you to each visit. New and established patients are also encouraged to bring any pertinent lab test results obtained from other doctor consultations.

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Office hours are Tuesday-Thursday 9-4. Friday 9-12 with exception of major holidays, please consult our calendar on our webpage. The answering system will take messages at all times. Please leave a message and our staff will call you during regular business hours.

Since our office is preventive and consultative, we are not an urgent care, emergency, on-call, after hours, weekends or holidays facility. We do not admit or care for patients in the hospital. We do not provide primary care services. (See primary care form). Patients should also consult and inform their primary care physician of the therapy received in this office for the coordination of patient care. Our staff does not have hospital privileges and we are unable to treat a patient at another facility. Additionally, all patients referred to specialists and/or for additional testing are personally responsible for following-up with these recommendations. If any of our patients are experiencing an emergency medical situation they are advised to contact 911.

All appointments must be confirmed within 24 hours of receiving our confirmation call. All patients who fail to arrive for their scheduled appointments or cancel with less than (2) business days advance notice will be charged a missed appointment fee..

The under (2) business day cancellation and missed appointment fees are as follows: Test Review, Follow-up, Yearly $150.00

New Patient $275.00 (due at time of making 1st appointment, non-refundable reschedule only)

**MEDICAL RECORDS**

Your medical records are subject to HIPAA policies. Please read our HIPAA/privacy information. Whenever possible, we obtain your direct consent for release of records regarding your care with us. However, the HIPAA policy requires us to release certain records to insurance or other care providers. A copy of your medical records is available upon request with a charge of $0.25 per page.

**SUPPLEMENTS**

Some of the supplements we prescribe are available at this office. A varied supply of high quality supplements is maintained. However, you are under no obligation to purchase these products from us. Some of the supplements are available through various health food stores and other sources. Please be advised, our supplements are purchased only through the most reputable sources who maintain a strict quality process. The use of supplements purchased elsewhere will not affect the quality of care by your physician here. Supplements can only be purchased here if prescribed by your physician. Off label use of medications and supplements are often recommended by this office. **Supplements may not be returned for refund after purchase at this office.** For your convenience, patients can call (650) 474-2130 to request supplement refills. These orders will be prepared and will be available for pick- up within 2 business days or can be shipped per your request within 7 business days with a shipping fee. For more information, please contact our office staff. Please note that insurance companies almost never consider nutritional supplements as covered items.

**PERFUMES, SCENTS, SMOKING & CELL PHONES**

Many of our patients (and staff) are made ill by perfume and other scented products. Please be considerate and use no perfume or scented products when you are coming into the office. Remember that perfume applied earlier in the day may still cause symptoms in allergic people. Patients wearing strong scents in the office may be requested to reschedule their appointments in order to protect other sensitive patients. Smoking is not permitted on the premises.

**We ask that you please do not use cell phones in treatment areas.** **Please sign when you have read and understood our office policy.**

*Signature Date*

**2019**

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**Integrative Medical Associates 1098 Foster City Blvd. #305 Foster City, CA. 94404**

**Phone: (650) 474-2130 INFORMED CONSENT FORM**

1. Many of the treatments offered at this office are considered to be alternative or complementary arts as compared to those considered allopathic or conventional. We use an innovative and integral approach to the myriad of complex factors causing chronic disease. We view an individual’s disease process as an imbalance in the complex interrelated components of all systems of the human body. There are many factors involved in the bio-regulatory system including genetic predisposition and vulnerability, physical, environmental, toxic or traumatic factors, psycho- emotional stress and trauma, malnutrition, and spiritual disharmony.

The therapeutic protocols we offer, especially treatments involving the administration of nutritional supplementation, herbal or homeopathic medicinal products, while derived from extensive scientific data implying hypothetical applications to treatment of specific disease, in large part must be considered investigational and/or experimental. We use therapies that are supported by extensive observation and anecdotal data collated by many physicians and investigators. These therapies have not been proven by double-blind placebo controlled studies.

These therapies are, by nature, relatively non-toxic when administered and complied with properly. However, as with medications, there is always a risk of an untoward, unpredictable reaction or adverse side effects.

1. In compliance with Business & Professions Code 2234.1 (a) (1) these alternative and/or complementary services may only be provided after
	1. informed consent, and
	2. a good-faith prior examination of the patient, and
	3. medical indication exists for the treatment or advice, or it is provided for general health or well-being.

Business & Professions Code 2234.1 (a) (3) and (4) states that the alternative and/or complementary treatments not cause a delay in, or discourage traditional diagnosis of, a condition of the patient, nor cause death or serious bodily injury to the patient.

1. By signing this form, I acknowledge I have been apprised of Business & Professions Code 2234.1. After being duly informed by my physician of my condition and the conventional allopathic treatments and common outcomes, including common adverse events, and the alternative and/or complementary treatments and common outcomes, including common adverse events, I will then decide whether to proceed with alternative and/or complementary treatments. If I proceed, it will be after being fully informed. It is also my choice to combine this treatment with conventional treatment or forgo conventional/allopathic treatment. My physician will respect my ability to make my own decisions and will not discourage me from seeking conventional/allopathic treatment.
2. The nature of the services to be provided is an evaluation and treatment of your complaints based on an extensive history and a directed or general physical examination. Treatments are based on the concept of biochemical individuality. Your response to the external and internal environments is generally similar to other human beings. However, many of us because of our genetic uniqueness and our individual life experiences react differently to a given stimulus. Conventional medicine has developed its expertise in dealing with severe physical trauma and life- threatening diseases. It is very effective in some of these areas. When the body or psyche is severely stressed, the general patterns of reaction are similar for most people. When the physical or psychic trauma is less overwhelming or chronic, our individual responses become more pronounced.

I, the patient, have been given my own copies of this form and any other written materials pertinent to my case.

Patient Signature: Date:

Printed Name:

CALIFORNIA LICENSE

D. Graeme Shaw, M.D. --- G47925

**2019**

**Integrative Medical Associates 1098 Foster City Blvd, #305**

**Foster City, CA 94404 (650) 474-2130**

Are you now, or will you be during the span of your treatment, a Medicare Beneficiary?

Yes No

If no-Patient (or parent/guardian) Signature Date

If yes, please continue to fill out the Medicare Agreement.

PRIVATE CONTRACT BETWEEN PHYSICIAN AND MEDICARE BENEFICIARY

This agreement is made between D. Graeme Shaw, M.D. Medical Doctor- whose principal place of business is: 1098 Foster City Blvd. #305, Foster City, CA. 94404 and -- , a patient and a Medicare beneficiary, who resides at .

(Address)

D. Graeme Shaw, M.D. agrees to provide medical services as listed in your new patient packet. In return for these services, the undersigned patient agrees to provide payment to physician in the amount set in your new patient information. By signing this, the patient agrees and understands the following:

Initial

 Patient is not currently facing an emergency or urgent health care situation.

 Patient agrees not to submit a claim (or request that a physician submit a claim) for the services provided pursuant to this agreement to the Medicareprogram.

 Patient agrees to be fully responsible, whether through insurance or otherwise, for payment of the services, and understands that no Medicare reimbursement will be provided.

 Patient understands that no Medicare reimbursement limits (including Medicare’s limiting charge) apply to the services in question.

 Patient understands that Medi-Gap plans do not, and other supplemental insurance plans may not, make payment for the services because payment is not made under the Medicare program.

 Patient acknowledges that patient has the right to have these items and services provided by other physicians for whom Medicare would make payment.

 Patient understands that Medicare payment will not be made for any items or services furnished by the physician that otherwise would have been covered by Medicare if there was no private contract and a proper Medicare claim.

 Patient understands that he/she enters into this contract with the knowledge that he or she has the right to obtain Medicare-covered services and items from physicians who have not opted out of Medicare, and that the beneficiary is not compelled to enter into private contracts that apply to other Medicare services furnished by other physicians who have not opted out.

 Patient acknowledges that a copy of this contract has been made available to him.

Physician is not excluded from participating in the Medicare Part B under Sections 1128, 1156,or 1892 or any other section of the social security act.

(Type or print name) (Patient’s signature)

 D Graeme Shaw M.D.

(Type or print name) (Physician’s signature)

## 2019



###### By: By:

Physician or (Date) Patient’s Signature (Date) Duly Authorized Representative

Print or Stamp Name of Physician/ Medical Grp Print Patient’s Name

By: By:

Signature of Translator (if applicable) (Date) Patient’s Representative (if applicable) (Date)

Print Name of Translator Print Name & Relationship of Patient Representative

Integrative Medical Associates 1098 Foster City Blvd. #305

Foster City, CA 94404

650-474-2130

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed an how you can get access to this information. Please review it carefully.

This notice takes effect on 4/01/03 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with the quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

1. OUR LEGAL DUTY

Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.

.Follow the terms of the notice that is now in effect.

We have the right to:

1.Change our privacy practices and the forms of this notice at any time, provide that the changes are permitted by law. 2.Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice change to Privacy Practices:

Before we make an important change in our privacy practices, we will change this notice and make the new notice available on request.

1. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

**FOR TREATMENT:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

**FOR PAYMENT:** We may use and disclose your medical information for payment purposes.

**FOR HEALTH CARE OPERATIONS:** We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

**ADDITIONAL USES AND DISCLOSURES:** In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

***Notification:*** Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

***Disaster Relief*:** Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

***Research in Limited Circumstances*:** Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

***Funeral Director, Coroner, Medical Examiner*:** To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

***Specialized Government Function*:** Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the

Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

***Court orders and Judicial and Administrative Proceedings*:** We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances. **Initial**

***Public Health Activities*:** As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

***Victims of Abuse, Neglect, or Domestic Violence*:** We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim or other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety or others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

***Workers Compensation*:** We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

***Health Oversight Activities*:** We may disclose medical information to an agency providing health oversight for oversight activities by law, including audits, civil, administrative, or criminal

investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

***Law Enforcement*:** Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws, such as requests of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

1. YOUR INDIVIDUAL RIGHTS

**You Have a Right To:**

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. You must make your request in writing. You may get the form to request access by asking one of our front desk staff. If you request copies of your medical records please allow up to fifteen days.
2. You have the right to review your records. You must coordinate a time with our front office staff to to do so.
3. Receive a list of all the times we or our business associates shared your medical information for purposes other that treatment. Payment and health care operations and other specified exceptions.
4. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
5. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our office.
6. Request that we change you medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes on any future sharing of that information.
7. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy officer at our office.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice of if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint **Initial**

**Patient Information**

DATE:

*Please print clearly with ink.*

Patient Name: Last First M.I.

Address: Street City State Zip

Home Phone: ( ) Cell: ( ) D.O.B. Sex: F/M Marital Status: S/M/D/W Drivers License: Employer Work Phone ( )

Occupation E-Mail

Responsible Party:

Patients’ Relationship: SSN#

Name: Last First M.I.

Address: Street City State Zip

Phone( ) Nearest Relative Phone ( )

Relationship to patient (in case of emergency) Insurance: (For Labs Only)

Insurance Carrier: I.D.#

Medicare#

**How did you hear about our practice?**

Internet: Google Facebook CNDA AANP

Yahoo

Advertisement Yelp Friend/family

Other:

Please check (X) for the following: I give permission to the staff to call and leave messages at my home and work phone number listed on the first page. I understand that a message may be left with a family member, co-worker, etc.

Yes \_No

##### OFFICE POLICY REGARDING PAYMENT AND INSURANCE

Payments for all professional services are due at the time services have been rendered. There will be a fee charged for a missed appointment unless a minimum of 48 hours is given. It is the goal of this office to provide the best possible medical care. In return it is your individual responsibility to pay

*in full* for this care, even though you may have insurance, you are solely responsible for the total amount. It is your individual responsibility to file your insurance claim. Your insurance company will then pay any amount allowed by your policy directly to you. We do not accept payment assignment.

This office does not fill out insurance forms however we gladly provide you the information necessary for you to file a claim. We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

I have read and understand the above paragraphs:

Signature of patient or person legally responsible

#  Health History Questionnaire

##### Name \_Date of Birth \_ Occupation \_Marital Status S M D

**Present Health History**

**Current Medical Problems**

###### Please list the medical problems for which you came to see the doctor. About when did they begin? Date Began

 \_ \_

 \_ \_

 \_ \_

**What concerns you most about these problems?**

If you are being treated for any other illnesses or medical problems by another physician, please describe the problems and write the name of the physician or medical facility treating you.

**Illness or Medical Problem Physician or Medical Facility City**

######  \_ \_

 \_ \_

**Medications**

Please list all medications you are now taking, including those you buy without a doctor’s prescription (such as aspirin, cold tablets or vitamin supplements)

##### Allergies and Sensitivities

List anything that you are allergic to such as certain foods, medications, dust , chemicals, or soaps, household items, pollens, bee stings, etc., and indicate how each affects you.

**Allergic To: Effect: Allergic To: Effect:**

##### General Health, Attitude and Habits

How is your overall health now? Poor Fair Good Excellent How has it been most of your life? Poor Fair Good Excellent **In the past year:**

Has your appetite changed? Decreased Increased Stayed the same

Has your weight changed? Lost #lbs Gained #lbs Stayed the same Are you thirsty much of the time? No Yes

Has your overall “pep” changed? Decreased Increased Stayed the same Do you usually have trouble sleeping? No Yes

How much do you exercise? Little or none \_Less than I need All I need \_ Do you smoke? No Yes If yes, how many years?

How many each day? Cigarettes Cigars Pipe fulls

Have you ever smoked? No Yes If yes, how many years? \_

How many each day? Cigarettes Cigars Pipe full’s

Do you drink alcoholic beverages? No Yes drink # Beers Glasses of wine Drinks of hard liquor -per day. Have you ever had a problem with alcohol? No Yes

How much coffee or tea do you drink? # of cups per day. Do you regularly wear seat belts? No Yes

**Do you: Rarely/ Occasionally Frequently Do you: Rarely/ Occasionally Frequently Never**

Feel nervous?

Feel Depressed Find it hard to make decisions? Lose your temper?

Worry a lot? Have any sexual problems? Have you recently had any changes in your:

Ever feel like committing suicide? Feel bored with your life?

Use Marijuana?

Use hard drugs?

Have trouble relaxing? Do you want to talk to the doctor about a personal matter? No Yes

Marital status? No Yes If so, please explain Job or Work? No Yes If so, please explain \_ Residence? No Yes If so, please explain Financial Status? No Yes If so, please explain Having any legal problems? No Yes If so, please explain

1

 Health History Questionnaire

##### Past History

**Family Health**

Please give the following information about your immediate family. Have any blood relatives had any of the following illnesses?

**Relationship Age if living Age at death State of Health/** If so, indicate relationship (mother, father etc.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Father |  \_ |   | **Cause of death**  | **Illness**Asthma | **Family member**  |
| Mother |  \_ |   |   | Diabetes |   |
| Brothers SistersSpouse |  \_ \_ \_ \_ \_ |       |       | CancerBlood Disease Glaucoma EpilepsyRheumatoid Arthritis |  \_     |
| Children |  \_ \_ \_ \_ |      |      | Tuberculosis GoutHigh Blood Pressure Heart Disease Mental Problems SuicideStroke |         |
| **Hospitalizations, Surgeries, Injuries** | Alcoholism |   |
| Please list all times you have been hospitalized, operated on, or seriously injured. | Rheumatic Fever |   |
| Illness | (X) | Year | Illness | (X) | Year |
| Eye or eyelid infection |   |   | Hernia |   |   |
| Glaucoma |   |   | Hemorrhoids |   |   |
| Other eye problems |   |   | Kidney or bladder disease |   |   |
| Ear Trouble |   |   | Prostate problem (male only) |   |   |
| Deafness or decreased hearing |   |   | Mental problems |   |   |
| Thyroid trouble |   |   | Headaches |   |   |
| Strep Throat |   |   | Head Injury |   |   |
| Bronchitis |   |   | Stroke |   |   |
| Emphysema |   |   | Convulsions/seizures |   |   |
| Pneumonia |   |   | Arthritis |   |   |
| Allergies/asthma/hay fever |   |   | Gout |   |   |
| Tuberculosis |   |   | Cancer/Tumor |   |   |
| Other lung problems |   |   | Diabetes |   |   |
| Heart attack |   |   | Measles/Rubeola |   |   |
| High cholesterol |   |   | German measles/Rubella |   |   |
| Arteriosclerosis |   |   | Polio |   |   |
| Hardening of arteries |   |   | Mumps |   |   |
| Heart murmur |   |   | Scarlet fever |   |   |
| Other heart condition |   |   | Chicken pox |   |   |
| Stomach/duodenal ulcer |   |   | Mononucleosis |   |   |
| Diverticulosis |   |   | Eczema |   |   |
| Colitis |   |   | Psoriasis |   |   |
| Other bowel problem |   |   | Venereal disease |   |   |
| Hepatitis |   |   | Genital Herpes |   |   |
| Liver trouble |   |   | HIV test |   |   |
| Gallbladder trouble |   |   | AIDS |   |   |
| **Men-questions 1-6****Women 7-14** |  |  |  |  |  |

**Men Only Yes No Rarely Occasionally Never**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Have you had or do you have prostate trouble?
2. Do you have any sexual problems/impotency?
 | Y Y  | N N  |  |
| 3. Is it hard to start your urine flow? ……………………………………………………………….. |  |  | R  | O  | N  |
| 4. Is urination ever painful? …………………………………………………………………………….. |  |  | R  | O\_  | N  |
| 5. Do you get up at night to urinate? ………………………………………………………………. |  |  | R  | O\_  | N  |
| 6. Has your urine ever been bloody or dark colored? ……………………………………… |  |  | R  | O\_  | N  |

#### 2

 Health History Questionnaire

**Women Only Yes No Rarely Occasionally Never**

Do you:

7. Have any menstrual problems? ………………………………………………………………….. R

1. Feel rather tense just before your period. ………………………………………………….. R

O\_ N

O\_ N

(Women continued) **Yes No Rarely Occasionally Never**

1. Do you:
	1. Have heavy menstrual bleeding? ……………………………………………………………….. R
	2. Have painful menstrual periods? ………………………………………………………………… R

Have bleeding between periods? ……………………………………………………………….. R

* 1. Have any vaginal discharge or itching? ……………………………………………………….. R

d. Ever have tender breasts? ………………………………………………………………………….. R

e. Have any discharge from your nipples? ………………………………………………………. R

f. Have any hot flashes? …………………………………………………………………………………. R

1. How many times (if any) have you been pregnant?
2. How many children born alive?

O\_ N

O\_ N

O\_ N

O\_ N

O\_ N

O\_ N

O\_ N

1. Are you taking birth control pills? Y N
2. Do you examine your breast for lumps every month? Y N
3. What was the date of your last menstrual period?

**Men and Women**

|  |  |  |
| --- | --- | --- |
| 15. | In the past year have you had any: |  |
| a. | Muscle or joint stiffness or pain due to sports, exercise or injury? …………….. |  |  | R  | O\_  | N  |
| b. | Pain or swelling in any joints not due to sports, exercise or injury?.............. |  |  | R  | O\_  | N  |
| 16. | Do you have dry skin or brittle fingernails? | Y  | N  |  |
| 17. | Do you bruise easily? | Y  | N  |
| 18. | Do you have any skin problems? | Y  | N  |
| 19. | In the last three months have you had: |  |  |
| a. | Sores or cuts that were hard to heal? | Y  | N  |
| b. | Any lumps in your neck, armpits, or groin? | Y  | N  |
| c. | Chills or sweat at night? | Y  | N  |
| 20. | Have you traveled out of the country in the last two years? | Y  | N  |
| 21. | Write in dates for the shots that you have |  |  |

had. \_

1. Have you had a turberculin (TB) skin test Y N
2. Has your vision changed in the last year? Y N
3. How often do you have:

Negative\_

Positive \_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| a. | Head colds?................................................................................................... |  | R  | O\_  | N  |
| b. | Chest colds?.................................................................................................. |  | R  | O\_  | N  |
| c. | Runny nose?.................................................................................................. |  | R  | O\_  | N  |
| d. | Stuffed up nose?........................................................................................... |  | R  | O\_  | N  |
| e. | Sore/hoarse throat?...................................................................................... |  | R  | O\_  | N  |
| f. | Bad coughing spells?..................................................................................... |  | R  | O\_  | N  |
| g. | Sneezing spells?............................................................................................ |  | R  | O\_  | N  |
| h. | Trouble breathing?........................................................................................ |  | R  | O\_  | N  |
| i. | Nose bleeds?................................................................................................. |  | R  | O\_  | N  |
| j. | Trouble breathing?........................................................................................ |  | R  | O\_  | N  |
| k. | Nose bleeds?................................................................................................. |  | R  | O\_  | N  |
| l. | Cough blood?.............................................................................................. |  | R  | O\_  | N  |
| 25. | Have you ever worked or spent time: |  |  |  |  |
| a. | On a farm? | Y N  |  |  |  |
| b. | In a laundry or mill? | Y N  |  |  |  |
| c. | In a very dusty place? | Y N  |  |  |  |
| d. | With or near toxic chemicals? | Y N  |  |  |  |
| e. | With or near radioactive materials? | Y N  |  |  |  |
| f. | With or near asbestos? | Y N  |  |  |  |
| 26. | Do you get out of breath easily when you are active, like climbing stairs? |  | R  | O\_  | N  |
| 27. | Do you ever feel light headed or dizzy?....................................................... |  | R  | O\_  | N  |
| 28. | Have you ever fainted or passed out? ......................................................... |  | R  | O\_  | N  |
| 29. | Do you ever feel your heart is racing/beating too fast? .............................. |  | R  | O\_  | N  |
| 30. | When exercising do you have pain in your chest our shoulders?................. |  | R  | O\_  | N  |
| 31. | When walking do you have cramps or pain in your thighs or legs?.............. |  | R  | O\_  | N  |
| 32. | Do you have to sit up at night to breathe easier? ........................................ |  | R  | O\_  | N  |
| 33. | Do you use two pillows at night to help you breathe better?...................... |  | R  | O\_  | N  |

#### 3

 Health History Questionnaire

34. Are you a restless sleeper? .......................................................................... R

35. Are you bothered by leg cramps at night? ................................................... R

36. Do you sometimes have swollen ankles or feet? ......................................... R

37. How often if ever:

a. Are you nauseated? ..................................................................................... R

b. Do you have stomach pains? ....................................................................... R

c. Do you have heartburn? .............................................................................. R

d. Do you have trouble swallowing your food? ............................................... R

e. Have you vomited blood?............................................................................. R

f. Are you constipated?.................................................................................... R

g. Do you have diarrhea?.................................................................................. R

h. Are your bowel movements painful?............................................................ R

i. Are your bowel movements bloody?............................................................ R

j. Are your bowel movements dark or black?.................................................. R

O\_ N

O\_ N

O\_ N

O\_ N

O\_ N

O\_ N

O\_ N

O\_ N

O\_ N

O\_ N

O\_ N

O\_ N

O\_ N

38. Have you ever had a colonoscopy?................................................................ Y N BIOTOXICITY

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Do you have any dental amalgams?
2. Do you or have you had Candida/Chronic yeast problems?
3. Have you ever had a tick bite?
 | Y Y Y  | N N N  | If yes, how many If yes, when and where? \_ |
| 4. Have you ever been exposed to mold in a house or building? | Y  | N  |  |
| 5. How often do you eat fish? Times per week \_ |  |  |  |
| 6. Do you have any detoxification problems? | Y  | N  |  |
| 7. Do you have or have you had liver problems or jaundice? | Y  | N  |  |
| 8. What is your blood type?  |  |  |  |

NUTRITION AND DIET

1. How often do you usually eat? Every hours
2. Do you diet frequently? Y N
3. Are you dieting now? Y N
4. Check the frequency you eat the following types of food**: > 1x a day Daily 3x week 1x week 2x month Less/never**
	1. Whole grain or enriched bread or cereal
	2. Milk, cheese or other dairy products?
	3. Eggs?
	4. Meat, poultry, fish?
	5. Beans, peas or other legumes?
	6. Citrus?
	7. Dark green or deep yellow vegetables?

List any food supplements or vitamins you take regularly: Additional Patient

Comments:

Patients Signature

Physicians

Notes:

#### 4

 Primary Care Policy

##### Integrative Medical Associates 1098 Foster City Blvd. #305 Foster City, CA. 94404

**Tel: (650) 474-2130**

This is to advise you as a patient our office is not a primary care facility. We do not provide primary care services or urgent care service. We require our patients to establish themselves with a primary care physician and provide our office with this information. Our staff does not have hospital privileges and we do not treat patients at any other facility. We do not provide urgent, acute or immediate care at our office. We do not have practitioners on call for emergencies. If any of our patients are experiencing an emergency medical situation, they are advised to contact 911.

**Please provide us with the contact information for your Primary Care Provider:**

#### Provider Name: Phone #:

Provider Address

City State Zip

**Please initial and sign if you do not have a current Primary Physician.**

####  I do not have a Primary Care Physician and I am aware that our office will not be responsible for my Primary care.

Name Signature Date:

**Would you like us to contact your primary care provider for a copy of your records? Yes \_ No**

If yes please ask for and fill out our Records Release form.

**Would you like us to contact your primary care provider to inform him/her of your care and treatments at this office? Yes No**

**If yes, I give my consent for the staff and practitioners at this office to provide information about my medical situation and treatments to my Primary Care provider.**

Name Signature Date: